Brain & Spinal Injury Trust Fund Commission

APPLICATION FOR DISTRIBUTION

GENERAL INFORMATION

Background

The Brain and Spinal Injury Trust Fund ("Trust Fund") was established by law to collect additional DUI fines and fees and distribute them to eligible persons and programs. The purpose of the funds is to provide care and rehabilitative services to citizens of the state with traumatic brain or spinal cord injuries. Funds are distributed according to criteria set by a fifteen-member Brain and Spinal Injury Trust Fund Commission ("Commission"), through Distribution Policies (available on the Commission's website at http://www.bsitf.ga.us, or through the Commission office).

People who have traumatic brain or spinal cord injuries may apply for funds to assist them in meeting any or all costs of receiving care and rehabilitative services. The goal of Trust Fund disbursements will be to support independence, inclusion in the community, consumer choice and self-determination.

Please contact the Commission office if you have questions or need more information.

Application

Applications may be submitted by mail, email (the signature page must, in addition, be submitted by hard copy), or fax. Submit completed applications to:

Brain and Spinal Injury Trust Fund Commission
2 Peachtree Street, NW, Suite 8-225
Atlanta, GA 30303
404/651-5112 Office
404/656-9886 Fax
Toll-free: (888) 233-5760
info-bsitf@dhr.state.ga.us

Application Forms will be reviewed and approved by the Commission or the Commission's designated representative, subject to ratification by the Commission, if a designated representative reviews the application.

Eligibility

A person is considered eligible for a disbursement from the Trust Fund if he/she:

- Has sustained a neurotrauma with brain or spinal cord injuries
- Is a citizen of the state at the time of application and during the provision of services in Georgia
- Has exhousted all other insurance and governmental funding sources, or the needed service is outside the scope of other funding sources or is not otherwise available within existing community resources or through other agencies or programs.

Eligibility for disbursement of funds DOES NOT confer any entitlement to an award.

Recipients of disbursements are expected to utilize the disbursement in accordance with the purposes identified during the application process. Failure to do so may affect continued eligibility for disbursements or result in denial of future applications for disbursements.

Individuals should make their own determination concerning the legal effects of receipt of a disbursement from the Trust Fund on other benefits.

For additional information, and for definitions of eligibility terms, please review the Commission's Distribution Policies at http://www.bsitf.ga.us.

Continued next page

Definitions

"Neurotrauma" is defined as an injury to the central nervous system, i.e. traumatic brain or spinal cord injury that is caused by external physical forces. Neurotrauma does not include:

1. Individuals who have had a CVA (cerebral vascular accident/stroke).
2. Spinal cord dysfunction for which there are no know or obvious injuries to the intracranial central nervous system.
3. Progressive dementias and other mentally impairing conditions.
4. Depressing and psychiatric disorders.
5. Mental retardation and birth related disorders.
6. Neurological degenerative, metabolic and other conditions of a chronic, degenerative nature.
7. Anoxic or hypoxic episodes, allergic reactions, or any other inflammatory infections or acute medical incidents.

"Traumatic brain injury" is defined as a traumatic injury to the brain, not of a degenerative or congenital nature, but arising from blunt or penetrating trauma or from acceleration-deceleration forces, that is associated with any of these symptoms or signs attributed to the injury: decreased level of consciousness, amnesia, other neurologic or neropsychologic abnormalities, skull fracture, or diagnosed intracranial lesions. These impairments may be either temporary or permanent and can result in a partial or total functional disability.

"Traumatic spinal cord injury" is defined as a traumatic injury to the spinal cord, not of a degenerative or congenital nature, but caused by an external physical force resulting in paraplegia or quadriplegia which can be a partial or total loss of physical function.

For additional information, and for definitions of eligibility terms, please review the Commission's Distribution Policies at http://www.bsitf.ga.us.

Goods and Services Covered

Goods and services considered for disbursements include, but are not limited to:

- Assistive Technology
- Durable Medical Equipment
- Health and Wellness
- Home Modifications
- Housing
- Medical, Dental, or Vision Services
- Neurobehavioral Programs
- Personal Support Services/Respite
- Psychological services/Counseling
- Recreation
- Transportation
- Employment support

Applications will be considered for other care and rehabilitative services if the requests otherwise meet the criteria for approval.

Costs for services or goods must be in line with costs the Commission has identified. Costs that are unusual or exceed the expected costs must be explained to the satisfaction of the Commission. Cost estimates and quotes from vendors must be attached to the Application For Distribution Form upon submission.

For more information on criteria and funding parameters, please review the Distribution Policies on the Commission website at http://www.bsitf.state.ga.us.

Brain & Spinal Injury Trust Fund Commission

APPLICATION FOR DISTRIBUTION

Applicant Information

Name of Applicant:

Street Address:

Mailing Address (if different from above):

City, State, Zip (please include last 4 digits if known):

Daytime Phone: Email Address:

Occupation:

Employer:

Social Security Number: Date of Birth:

Name of Person Completing Application (if different from Applicant):

Mailing Address:

City, State, Zip (please include last 4 digits if known):

Daytime Phone: Email Address:

Relationship to Applicant:

Ethnicity: ☐ Caucasian ☐ African American ☐ Asian/Pacific Islander ☐ Hispanic or Latino
☐ Other:_____ ☐ Decline to state

For Commission Office Use Only:

Application # _____ Region # _____ Review Date: _____

Continued next page

Residency Requirements

Resident of Georgia: ❒ Yes ❒ No

County of Residence: _____

If you are employed, are you employed or engaging in any trade, profession or occupation in Georgia? ❒ Yes ❒ No

Is the above street address a permanent home or abode in Georgia to which, whenever you are absent, you intend to return? ❒ Yes ❒ No

If you have school age children, have you entered your children to be educated in the private or public schools of Georgia? ❒ Yes ❒ No

Have you been present in Georgia for thirty (30) or more days? ❒ Yes ❒ No

Are you a United States citizen? ❒ Yes ❒ No

If not a U.S. citizen, are you an alien with legal authorization from the U.S. Immigration And Naturalization Service? ❒ Yes ❒ No

Access to Other Resources

The Trust Fund is intended to be the funding source of last resort. Other funding sources are often available for requests such as computers, assistive technology, adaptive equipment, etc. Accessing these funding sources will maximize the Trust Fund dollars available to you. Please see the Resource Guide included in this application kit in order to find out more.

You must fill out this section in its entirety.

	Awaiting Eligibility	Eligible & Enrolled	Have applied, but not eligible	Not Applicable
PERSONAL SUPPORT SERVICES				
Community Care Services (CCSP)	❒	❒	❒	❒
Independent Care Waiver Program (ICWP)	❒	❒	❒	❒
SOURCE Waiver	❒	❒	❒	❒
FINANCIAL RESOURCES				
Medicaid	❒	❒	❒	❒
Medicare	❒	❒	❒	❒
SSI	❒	❒	❒	❒
SSDI	❒	❒	❒	❒
Private Insurance	❒	❒	❒	❒
Short Term Disability	❒	❒	❒	❒
Long Term Disability	❒	❒	❒	❒
Vocational Rehabilitation (VR)	❒	❒	❒	❒
PASS Plan	❒	❒	❒	❒
Indigent Care Trust Fund	❒	❒	❒	❒
Veteran's Administration	❒	❒	❒	❒
OTHER FUNDING SOURCES				
Centers for Independent Living	❒	❒	❒	❒
Victims Compensation Fund	❒	❒	❒	❒
Friends of Disabled Adults and Children	❒	❒	❒	❒
Assistance Technology Resource Centers	❒	❒	❒	❒

Are you currently living in a nursing facility, group home, personal care home or other facility?

❒ Yes ❒ No

If yes, please describe: _____

_____

Support Systems

❒ Family in state ❒ Caseworker ❒ None _____

❒ Family out of state ❒ Clergy/Faith Community

❒ Friend/Neighbor ❒ Other _____

Continued next page

Description of Injury

Nature of Injury (Check all that apply):

- ❒ Traumatic Brain Injury
  - ❒ Mild TBI
  - ❒ Moderate TBI
  - ❒ Severe TBI
- ❒ Spinal Cord Injury
  - Paraplegic - What level? _____
  - Quadriplegic - What level? _____

Date of Injury: _____

Please describe how your injury ocurred:

_____

_____

_____

_____

Please provide a letter from a physician, medical practitioner, hospital clinic or other medical or medically related facility, or insurance company, verifying the nature and cause of your injury. Letters that do not specify the nature and cause of the injury cannot be accepted.

Description of Request

Please describe briefly the services or goods you are requesting. Total cost of all requests may not exceed $5,000. If you are requesting more than one service or good, please list them in order of priority:

Example:

Item:	Amount:
1. Attendant care 3 times a week for 4 hrs. a day ($25/hr.) for 2 months	$2,400.00
2. Van lift 1 hydraulic Lift	$1,750.00
3. Hand Control 1 set of hand controls	$350.00

Item:	Amount:
1.	
2.	
3.	
4.	
5.	
Total	

Trust Fund does not reimburse sales tax. DO NOT include sales tax in your request.

You must provide a cost estimate for each service or good requested.

Continued next page

Description of Request
(continued)

If you are awarded, how will the award allow you to be more independent?

How will the award allow you to be more a part of your community?

What will happen if you are not approved for a distribution?

If the service or good you are requesting costs more than $5,000, how will you pay for the remaining costs if you are approved for a distribution?

Continued next page

Description of Request *(continued)*

What agency, vendor or individual provider will provide the requested services if funds are approved?

1.Service or Good:

Provider: _____

Address: _____

_____

Phone: _____

Contact person: _____

2.Service or Good:

Provider: _____

Address: _____

_____

Phone: _____

Contact person: _____

3.Service or Good:

Provider: _____

Address: _____

_____

Phone: _____

Contact person: _____

4.Service or Good:

Provider: _____

Address: _____

_____

Phone: _____

Contact person: _____

Continued next page

Certification, Representations, Assurances, and Acknowledgments

A. By signing below, I certify to the Commission that:

1. I have read and understand the Commission's Distribution Policies (for a copy of the Policies, go to); and
2. I have provided truthful, complete and accurate information on this application; and
3. I have exhausted all other insurance and governmental funding sources before applying to the Commission.

B. I represent and assure the Commission that, if I am granted funds, I will:

1. Use the funds for the purpose stated in this application; and
2. Promptly report in writing to the Commission any change in the availability of insurance and governmental funding sources that may affect my eligibility for funds.

C. I understand and acknowledge that:

1. The Commission has the right to rely on the information contained in this application or any subsequent amendments; and
2. The Commission has the right to withdraw or modify any disbursement in the event that:
   a. The information contained in this application or any subsequent amendment should at any time be determined to be false, incomplete, inaccurate, or misleading; or
   b. The funds are used for a purpose other than that stated in this application; or
   c. The Commission becomes aware of any change in my status or circumstances that may affect my eligibility; and
3. The Commission's determination may affect not only continued eligibility but also affect future eligibility for qualification; and
4. It is my responsibility to determine if the receipt of funds legally impacts other benefits that I may receive.

_____

Signature

_____

Date

(For applications submitted by email, this signature page must, in addition, be submitted by hard copy.)

Release/ Authorization

By signing below, I hereby authorize the following persons and/or institutions that have any records or knowledge of me, my employment, and my health to give any such information to the Brain and Spinal Injury Trust Fund Commission (the "Commission") or its designee and its legal representatives:

- Any physician, medical practitioner, hospital clinic or other medical or medically related facility, insurance company, Third Party Administrator, the Medical Information Bureau or any similar organization, institution or person, any employer, group plan holder or certificate holder.
- If the record released contains information relating to HIV test results, AIDS, alcohol abuse or mental health care, enough of this information is to be released to accomplish the purposes for which the information is requested and to the extent permitted by law.
- I understand that the information released to the Commission may be used to process my application for disbursement from the Trust Fund and may be given to any person or entity carrying out a function for, on behalf of or in conjunction with the Commission.
- This information may also be redisclosed as otherwise specifically required or permitted by law.
- This authorization shall remain in effect until revoked by me in writing.
- I may obtain a photocopy of this authorization upon request.

_____

Signature

_____

Date

(For applications submitted by email, this Release/Authorization must, in addition, be submitted by hard copy.)

The Commission does not consider itself a "covered entity" for purposes of the Health Insurance Portability and Accountability Act of 1996 (HIPPA)

APPLICATION FOR DISTRIBUTION

CHECKLIST

Please include this form in your application.
For an application to be complete, it must include the following:

- ❒ Full application, with complete answers to each question
- ❒ Signatures on pages 6 and 7 of application *(submit a hard copy if the application is being submitted by email)*
- ❒ Letter from a physician, medical practitioner, hospital clinic or other medical or medically related facility, or insurance company, verifying the NATURE and CAUSE of your injury. Letters that fail to indicate both the NATURE and CAUSE of your injury will not be sufficient
- ❒ Cost quotes or estimates from the vendor, company, or organization (provider) that will provide the requested service, indicating the cost of the requested service
- ❒ Copies of written denials from other sources if available

For requests that are medical or therapeutic in nature:

- ❒ Letter from a physician, verifying the need for the requested service or product
- ❒ For rehabilitative, neuropsychological, and other therapies, a list of measurable goals for services, expected length of time for services, and frequency of services
- ❒ A cost estimate for service, written by provider

For vehicle requests:

- ❒ Current valid Georgia driver's license or learner's permit, or documentation of eligibility for a Georgia driver's license or learner's permit
- ❒ Doctor's note confirming your ability to drive
- ❒ If driver is other than the applicant, a current valid Georgia driver's license or learner's permit license or learner's permit, or documentation of eligibility for a Georgia driver's license or learner's permit
- ❒ Documentation of disabled drivers accessment

For modifications to a vehicle, the vehicle must meet the following guidelines:

- ❒ Full-sized van must be a model year 5 years or less than the current model year at the time of the application and have no more than 50,000 actual miles
- ❒ Mini van must be a model year 3 years or less than the current model year at the time of application and no more than 36,000 actual miles
- ❒ Other vehicles must be a model year 10 years or less than the current model year at the time of application; if a vehicle is from a model year more than 5 years from the current model year it must be certified by an ASE certified mechanic and you must provide proof of certification in application

For requests for Home Modifications:

- ❒ A statement indicating whether the home to be modified is rented or owned
- ❒ Documentation of ownership of the home
- ❒ If the applicant does not own the home, a letter from the owner of the home indicating consent for the requested modifications
- ❒ A cost estimate for service, written by provider

Please include this form in your application.

Brain & Spinal Injury Trust Fund Commission

FREQUENTLY ASKED QUESTIONS

To assist those who are interested in applying for disbursements from the Brain and Spinal Injury Trust Fund, the following questions may help you decide whether to apply and what you can expect if you apply. The Commission strongly encourages all readers to review the Distribution Policies in their entirety. In the event of any conflict between the responses to these Frequently Asked Questions and the actual published Commission policies, the policies shall control. The Commission encourages anyone who receives this document to share it with others who might be interested in applying for grants.

Can an individual apply directly to the Commission for a grant?

Yes. You may apply for an award. Anyone interested in receiving an award must fill out an application and submit it and other required documents to the Commission.

What if I am not able to complete the application?

You may have someone complete the application on your behalf. It may be a family member, a friend, or a guardian.

Is there a deadline to submit the application?

No. Applications are taken on an on-going basis.

Is the Trust Fund an "entitlement"?

No. A grant from the Trust Fund is not a permanent source of funding for an individual. An eligible application is not a guarantee of receiving funds.

How long will it take to review my application?

The Commission anticipates that the review process will take 6 – 8 weeks.

If I am approved for a disbursement, when will I receive the funds?

Once you have been approved for a disbursement, you will need to complete some paperwork for your provider(s). The form should be completed then returned. Upon receipt, it will take approximately 2 –3 weeks.

How much money will be available for disbursement from the Trust Fund?

The amount available depends on appropriations from the Trust Fund made by the Georgia General Assembly. This funding will be distributed, based upon population, among 10 modified Public Health districts.

Continued next page

How much money can I apply for?

It is anticipated that no distributions, totaling in excess of $5,000 per applicant will be approved per fiscal year.

Will the check be made out to me or to the provider?

The check will be made out to the provider, unless you receive approval by the Commission office to receive a check directly. This is particularly important if you are receiving government benefits, since the income from the Trust Fund could negatively impact the benefits you receive. You will need to determine the legal effects of receipt of a disbursement from the Trust Fund on other benefits.

Can the Trust Fund reimburse me for past expenses?

No. The Trust Fund cannot pay for goods and services that have already been rendered or delivered at the time of the application.

If I have applied before and want to apply again, do I have to complete the entire application

Yes. You will need to complete a new application with information related to your new request. You will not need to resubmit documentation of your injury.

Do I have to use a specific provider or can I choose my own?

You can choose your own provider. The Commission may seek basic information about the provider's ability to deliver the good or service. The Commission has also included with the application, a referral list of Preferred Providers who work with people with brain or spinal cord injury. The provider you choose may fill out a simple application to be placed on this referral list.